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ABSTRACT

This digest discusses the most frequently diagnosed mood disorders in children and adolescents, including major depressive disorder, dysthymic disorder, and bipolar disorder. The symptoms of these disorders are described, along with family and genetic causal factors, biological causal factors, and cognitive causal factors. The digest then addresses the diagnosis and assessment of depressive illness in young people and treatment of depressive disorders. Educators are urged to provide a positive and supportive environment, components of which include satisfaction of basic needs, caring relationships with adults, and physical and psychological security. It stresses that any inclusion in a student's program that serves to enhance feelings of self-worth, self-control, and optimism has the potential for ameliorating feelings of depression. Educators are also urged to use instructional strategies that are both positive and effective, so that the student will achieve success and enjoy the learning process. Examples include direct instruction with positive reinforcement, thematic instructional units with varied levels of classroom assignments, learning strategies, and utilization of principles of universal design for learning that promote access to the general curriculum for students with learning problems. (Contains 17 references.) (CR)

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Depression and Disability in Children and Adolescents

Eleanor Guetzloe

For many years, depression and other disorders of mood were thought to be afflictions of only adults. Within the past three decades, however, it has become evident that mood disorders are common among children and adolescents. Population studies reveal that between 10% and 15% of the child and adolescent population exhibit some symptoms of depression (U. S. Department of Health and Human Services [USDHHS], 2000).

In children and adolescents, the most frequently diagnosed mood disorders are major depressive disorder, dysthymic disorder, and bipolar disorder. This digest focuses on these three disorders as they are exhibited in childhood and adolescence—their symptoms, causal factors, and treatment.

Major Depressive Disorder

Major depressive disorder is a serious condition characterized by one or more major depressive episodes. In children and adolescents, an episode lasts an average of seven to nine months (Birmaher et al., 1996a, 1996b). Depressed children are sad and lose interest in activities they used to enjoy. They feel unloved, pessimistic, or even hopeless; they think that life is not worth living; and they may think about or threaten suicide. They are often irritable, which may lead to disruptive or aggressive behavior. They may be indecisive, have problems concentrating, and lack energy or motivation. They may neglect appearance and hygiene, and their normal eating and sleeping patterns may be disturbed (USDHHS, 2000).

Dysthymic Disorder

Dysthymic disorder has fewer symptoms, but is more persistent. The child or adolescent is depressed for most of the day on most days, and symptoms may continue for several years, the average dysthymic period being approximately four years. Seventy percent of children and adolescents with dysthymia eventually experience an episode of major depression. When this combination of major depression and dysthymia occurs, the condition is referred to as double depression (USDHHS, 2000).

Bipolar Disorder

In bipolar disorder, episodes of depression alternate with episodes of mania. The depressive episode usually comes first, with the first manic features becoming evident months or even years later. Adolescents with mania feel energetic and confident; may have difficulty sleeping but do not tire; and talk a great deal, often speaking very loudly or rapidly. They may complain of racing thoughts. They may do schoolwork quickly and creatively, but in a chaotic, disorganized way. In the manic stage, they may have exaggerated or even delusional ideas about their capabilities and importance, become overconfident, and be uninhibited with others. They may engage in reckless behavior (e. g., fast driving or unsafe sex). Sexual preoccupations are increased and may be associated with promiscuous behavior (USDHHS, 2000).

Other Disabilities Associated With Depressive Disorders

Approximately two-thirds of children and adolescents with major depressive disorder also have another mental disorder, such as anxiety disorder, conduct disorder, oppositional defiant disorder, psychoactive substance abuse or dependence, or phobias (Anderson & McGee, 1994). Authorities have also noted that children with medical problems often face extreme and/or chronic stress, which places them at risk for depression. Estimates of depression among youngsters with medical problems range from 7% in general medical patients to 23% in orthopedic patients (Guetzloe, 1991). Depression has also been linked to a variety of other medical conditions, including endocrinopathies and metabolic disorders (e.g., diabetes and hypoglycemia), viral infections (e.g., influenza, viral hepatitis, and viral pneumonia), rheumatoid arthritis, cancer, central nervous system disorders, metal intoxications, and disabling diseases of all kinds. Some of these conditions may be temporary, but some may be diagnosed as primary disabilities in youngsters with health impairments.

The Link Between Depression and Suicide.

A number of studies have confirmed that children and adolescents with depression are at high risk for suicidal behavior (see Guetzloe, 1991). Because mood disorders substantially increase the risk of suicide, suicidal behavior is a matter of serious concern for parents, educators, and clinicians who deal with the mental health problems of children and adolescents. Over 90% of children and adolescents who commit suicide have a mental disorder (USDHHS, 2000).

Causal Factors Related to Depression

The precise causes of depression are not known. Research on adults with depression generally points to both biological and psychosocial factors, but there has been considerably less research on children and adolescents (Kendler, 1995).

- ***Family and genetic factors***. Between 20% and 50% of depressed children and adolescents have a family history of depression. It is not clear whether the relationship between parent and childhood depression derives from genetic factors or if depressed parents create an environment in which children are more likely to develop mental disorders (USDHHS, 2000).
- ***Biological factors***. Biochemical and physiological correlates of depression have been studied by medical researchers, with results that generally point to a chemical imbalance in the brain as a causal factor (Birmaher et al., 1996a,1996b). Most of these studies have been conducted with adults, so the findings may not apply to children and adolescents (Guetzloe, 1991).
- ***Cognitive factors***. For several decades there has been considerable interest in the relationship between a pessimistic mindset and a predisposition to depression. Pessimistic individuals generally react more passively, helplessly, and ineffectively to negative events than optimistic individuals. The specific origins of pes-

simistic mindset have not been established (USDHHS, 2000) but are topics of current research interest (Alloy et al., 2001; Garber & Flynn, 2001).

Diagnosis and Assessment of Depressive Illness in Young People

Recent research has focused on the development and validation of checklists and protocols to be used by mental health professionals along with clinical interviews and medical tests. An accurate diagnosis of depression is a complex task, extremely difficult for even highly skilled physicians and other clinicians. It requires a careful examination of physical, mental, emotional, environmental, and cultural factors related to the child or adolescent, his/her family, and the environment. Teachers, counselors, and other school personnel are not expected to diagnose depression in young people; the major roles of educators are to detect the symptoms of depression and make appropriate referrals.

Treatment of Depressive Disorders

Treatment approaches for children and adolescents include psychosocial interventions (e. g., cognitive behavior therapy) and medication, as well as traditional psychotherapy. Two forms of cognitive therapy (i.e., self-control therapy for prepubertal children and coping skills for adolescents) have been judged as probably effective (Kaslow & Thompson, 1998).

A number of medications are commonly prescribed for children and adolescents with depression, but many of these have not yet been subjected to sufficient study. Effective treatment requires intervention by both medical and mental health professionals, with support from all others who come in contact with the young person; and is therefore not within the purview of the school alone.

School and Classroom Intervention

The educator's most important contribution is the provision of a positive and supportive environment, components of which include satisfaction of basic needs, caring relationships with adults, and physical and psychological security. Any inclusion in a student's program that serves to enhance feelings of self-worth, self-control, and optimism has the potential for ameliorating feelings of depression. Aversive techniques (e. g., punishment and "get tough" approaches) should be avoided to the extent possible (Guetzloe, 1989, 1991).

Educators must use instructional strategies that are both positive and effective so that the student will achieve success and enjoy the learning process. Examples include direct instruction with positive reinforcement, thematic instrucional units with varied levels of classroom assignments, learning strategies (e. g., mnemonic devices) and utilization of the principles of universal design for leaning, which promote access to the general curriculum for students with learning problems. Some protective factors have been addressed in published curicula (e. g., preventing alienation, enhancing self-esteem, and learning self-control). Other interventions that have implications for school programs (e. g., phototherapy and exercise) have been found to have value in reducing symptoms of depression in adults (Brosse, Sheets, Lett, & Blumenthal, 2002; USDHHS, 2003), but have not yet been subjected to sufficient study with children and adolescents.

Summary

Mood disorders, including major depression, dysthymia, and bipolar disorder, are now recognized as serious problems among children and adolescents. This brief discussion has focused on the symptoms of these disorders, their relationships to other mental and physical problems, their treatment, and appropriate school intervention.

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Depression & Bipolar Support Alliance (DBSA)
www.DBSAlliance.org

National Alliance for the Mentally Ill (NAMI)
http://www.nami.org

National Foundation for Depressive Illness, Inc.
http://www.depression.org

National Institute of Mental Health
http://www.nimh.nih.gov

National Mental Health Association (NMHA)
http://www.nmha.org

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